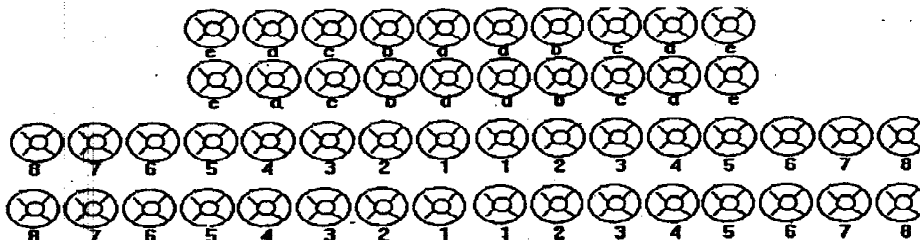


CONTINUOUS DENTAL RECORD FOR CHILDREN IN FOSTER CARE

Name of Child _____

Age _____

Name of Home or Facility _____



LEGEND

Filling Present	Fill in with <u>black</u>	Missing Teeth	Indicate with large black M
Cavities	Outline surfaces involved in <u>red</u> Draw parenthesis around when filled - ()	Teeth Indicated for Extraction	Indicate with large red X
Gum Inflammation	Indicate in red beneath teeth involved	Teeth Extracted	Indicated with large black X

EXAMINATION			
Deciduous teeth: Decayed? Stained? Calculous? Describe:		Permanent teeth: Decayed? Stained? Calculous? Describe:	
Gums Inflammation? Describe:		Mucous membranes Describe:	
Other oral manifestations Describe:			
Do irremediable defects of the teeth exist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is adequate fluoride present in the water supply? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is malocclusion present? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have fluoride applications been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	

RECOMMENDATIONS

- ☐ X-Rays ☐ Restorations ☐ Extractions ☐ Other
☐ Dental Prophylaxis ☐ Fluoride Applications ☐ Orthodontic Service

Continuous record of all services rendered on other side. _____

Signature _____

Date _____

Each entry must be identified by signature of dentist or dental hygienist.

Each entry must be identified by signature of dentist or dental hygienist.

[illegible]